TOWN OF TRURO

BOARD OF HEALTH

24 Town Hall Road, P.O. Box 2030, Truro, MA 02666
Tel: 508-349-7004, Extension: 32 or 31 Fax: 508-349-5508
Email: ppajaron@truro-ma.gov or adavis@truro-ma.gov

APPLICATION FOR FOOD SERVICE PERMIT

PART I - TO BE FILLED IN BY APPLICANT

Applicant: *(check one)* □ New □ Renewal **Date:** _____

Type of Food Service Establishment :
□ Food Service (restaurant or take out)
□ Retail Food (commercially prepared foods)
□ Residential Kitchen
□ Bed & Breakfast w/Continental Breakfast
□ Catering
□ Manufacturer of Ice Cream/Frozen Dessert
□ Bakery

Business Name: _____

Owner Name: _____ **Email Address**: _____

Mailing Address:_____

Phone No: _____ **24 Hour Emergency:** _____

Person Directly Responsible for Daily Operations: (Owner, Person In Charge, Supervisor, Manager)

Name: _____ **Email Address**: _____

Mailing Address:_____

Phone No: _____ **24 Hour Emergency:** _____

Number of Seats: Inside: _____ Outside _____Number of Employees: _____

Length of Permit: □ **Annual** □ **Seasonal Operation**

Hours of Operation: Mon-Fri: _____:_____ To _____:_____

Days Closed Excluding Holidays: _____

If Seasonal: Approximate Dates of Operation: _____/____/____ To ____/____/____

Certified Food Manager(s) (attach copy): (at least 1 full-time equivalent PER SHIFT required)

_____ _____ _____

Allergen Awareness Certification (attach copy):

_____ _____ _____

Has your menu changed from last year? ☐ Yes ☐ No
If yes please attach copy of menu or provide description of food to be prepared and sold:
_____
_____

I, the undersigned, attest to the accuracy of the information provided in this application and further agree to allow the regulatory authority access to the food service establishment as specified under § 8-402.11. I affirm that the food establishment operation will comply with 105 CMR 590.000, Truro Board of Health Regulation Section X, Food Service Regulations and all other applicable laws. Pursuant to MGL Ch. 62C § 49A, I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid state and local taxes required by law.

Signature of Applicant: _____ Date: _____

Social Security Number or Federal ID:

_____

FOR HEALTH DEPARTMENT USE ONLY

☐ Food Manager Certification ☐ Allergen Awareness Certification ☐ Choke Saver Training ☐ ☐ Workers Comp Affidavit ☐ Copy of Liability Insurance ☐ Copy of Commercial Hood/Ventilation System Report ☐ Copy of Dishwasher Service Report

Comments: _____

Application Approved _____ Denied_____

_____
Signature of Health Agent Date